Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

The Pain of Symptom Magnification

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One of the greatest issues we face as clinicians is when the patient's complaints don't seem to make sense, or worse, seem to be fabricated. For a long time, if a diagnosis was not clear it was usually assumed the patient was deliberately trying to mislead the doctor for secondary gain - to get drugs, for personal attention or because they "had issues." With the current trends in pain management, much has been said about the nature of a patient's pain and the standards a physician must abide by to evaluate and care for that individual.

Pain can be defined as "an unpleasant *sensory* and *emotional* experience associated with actual or potential tissue damage, or described in terms of such damage." As pain is experienced in the mind and requires the mental interpretation of bodily sensations, there is a psychological overlay to every pain problem. Pain is an individual experience and there is no way truly to know how much another person is in pain. When discussing complaints with a patient, it is best to assume the pain exists whenever a patient says is does, and that the pain is whatever the patient says it is. Telling a person they are not in pain basically puts the patient at odds with the doctor and forces the patient to validate their complaints.

Often with an acute injury, obvious physical signs such as swelling, heat or spasm are apparent. Orthopedic testing is very clear and yields a straightforward diagnosis. Conditions that have become chronic (lasting longer than three months) are more difficult to quantify because there are often few gross physical signs, and orthopedic testing does not yield a clear clinical picture. Such cases are considered the grist of pain management clinics because they are so difficult to diagnose and treat. So, what does a doctor do?

Whenever a patient presents to the office with a complaint, the evaluation is critical. This evaluation starts with a good history - getting a thorough history of the patient's condition will tell you more about the condition than will your physical exam.[1] The interview cannot be too detailed. Make sure you take time to ask specifics (e.g., origin, character, exacerbating factors). Have the patient define the area of pain (e.g., dermatomal, myotomal). Your questions should guide the patient to give you relevant information, and should be posed to identify the physical, psychological and/or emotional issues that obviously bear a great deal on the person being examined. Asking "How is your day going?" or "How has your week been?" gives insight into emotional distress that can increase the patient's pain level. Depression always impacts how one is feeling; and a nasty boss, a divorce or problems with teenagers can tell an additional story. Once you have asked your questions, give the patient time to tell you what is on their mind. Too often a patient is rushed through an exam by a doctor. Just listening and letting them talk will give the patient a sense that you care and are interested in their case. With a clear history, your exam will be more focused and should better direct your examination.

During your consultation, remember that there are different types of pain: Acute pain is often sharp and localized, while chronic pain may be deeper and vaguer. Getting the specific details of a complaint

will help to guide your clinical thinking. Also remember that chronic irritation often can lead to hyperfacilitation of nerves and tissues, making them far more sensitive than one would normally expect. These factors must be considered before beginning an exam.

Your consultation also must branch out into other aspects of the patient's life. Details about these activities will provide insight into how the complaint affects the patient's normal routine. For example, if a retiree is no longer able to work in her garden, that physical limitation can be a huge upset to her recreational enjoyment and emotional well-being. On the other hand, if a young man can't drive a truck due to neck and upper back pain, but can participate in his bowling league tournament, you might start to question the legitimacy of his complaints. If you find it appropriate to inquire during your interview, a patient's sexual habits also are telling. It is well-documented that patients with legitimate pain syndromes often have no desire for sexual intimacy.

The physical examination validates what you suspect during your interview and will help to define the objective parameters of the condition. Again, pay attention to what the patient says; how they respond to different maneuvers gives great insight. Do they demonstrate a positive "jump sign" when you palpate over the area of pain? Are you able to palpate myofascial adhesion or joint fixation? Do the orthopedic findings support the suspicions raised in your interview?

If diagnostic studies are available, always include these in your assessment. Radiographs may not have been taken to assess joint dysfunction, but that does not mean they are useless. Look at the area in question: Is there a soft tissue shadow? Is there sclerosis in the joint space? Are there bony spurs from previous irritation? Are the joint spaces intact? Remember, you can infer a great deal about the character of the regional soft tissues from the position of the bones.

Beyond all the normal activities of patient assessment comes the point at which you must decide whether what the patient says is confirmed by your examination findings. If you have valid findings, pursue the appropriate course of care for that patient. If you do not feel the patient's complaints are legitimate, you are still responsible for that patient. How you choose to treat them and what you document about them become even more important.

First, remember that patients do not have a great understanding of anatomy and medical terminology. Often, a patient will use a term they think is correct to describe what they feel. How many times have you had someone tell you they have sciatic pain down the front of their leg? That is not a lie. More often than not, John Q. Public will call any leg pain "sciatica." This is where a good patient interview helps you truly to understand what the patient's complaints actually are.

This is a good time to point out that "symptom magnification" is fairly common. Symptom magnification is defined as the patient exaggerating or magnifying their actual complaints in order to "sell" the doctor on the truth of their claims. Symptom magnification should not be confused with the term "malingering," which is defined as the deliberate and fraudulent feigning of symptoms. Actual malingering is rare, while symptom magnification is expected among the majority of patients.[2]

Next, your examination should confirm your working diagnosis. As stated above, the orthopedic tests should validate the suspicions raised in the interview. Again, few patients have an educational background in physical examination, so the use of different maneuvers can help to define the actual root of the pain. If a cervical compression test causes pain in the right neck, distraction lessens the pain and flexion and extension to that side increases it; one would suspect a facet problem. Using a

battery of similar tests only helps build a more specific diagnosis. Further, multiple tests help to validate questionable findings. If there is a positive straight leg raise test (read 'The Straight Leg Raise Test' from the May 8, 2006 issue of DC at www.chiroweb.com/archives/24/10/20.html) with a positive Bragard's and Sicard's, one would expect to see a positive seated straight leg raise, lasegue or seated lasegue. When similar tests performed with the patient in different positions change the finding, that should be a red flag for you to be more careful with your exam. Such a finding does not automatically mean the patient is not being truthful, but you are obligated to continue your examination until you have defined the root of the patient's complaints.

Beyond the physical examination comes the psychometric evaluation. Using outcomes assessment questionnaires like the Rand-36 or the Oswestry give you perspective on how the patient's *perception* of their pain affects their ability to pursue their daily activities. One may choose to order a professional psychological profile, not because the person is crazy, but because pain is processed in the mind; and the way in which the mind processes and deals with pain greatly affects the patient's ability to cope and respond to treatment.

Sadly, it is a fact of life that there are doctors that do profiteer off of a patient's perceptions. A less-than-reputable physician can take advantage of the patient's complaints and treat a "non-entity" until a minor problem becomes a chronic pain syndrome. Symptom magnification, in many cases, is brought on and reinforced by physicians prescribing medications and physical therapy for patients who do not need them.[2] Treatment must be tailored to the patient's needs at that time to produce maximal benefit.

If you truly believe your patient is feigning symptoms, then you must pursue testing to document that suspicion. Remember to watch for the "jump sign" - such a finding should be reproducible. Orthopedic maneuvers such as Magnuson's (the distraction test), Mannkopf's and the marked pain-suggestibility test can confirm your suspicions. As always, you must thoroughly document your findings.[3,4]

If you reach a point where you are truly unable to justify your patient's complaints, then you must be able to tell them in a way that is not going to put you in an antagonistic situation. Too often patients are confronted with their "lies" when the doctor has simply exhausted his abilities. In the legal realm, you can state that you are not able to justify the patient's complaints by objective measures, but you must then give recommendations for further evaluation or treatment. To evaluate a patient is to assume a measure of responsibility for their health care. You cannot just brush them off as a faker. If you confront a patient, you must explain what your findings are and what you are going to recommend, and why you recommend that course of treatment. If you refer that patient to another practice or specialist, you must explain your reasons and document the discussion.

No patient situation is the same. Some patients are just difficult: It might be their personality, they might have another agenda, they may just be having a bad day. It is impossible for any one doctor to be able to treat every complaint of every patient. Pain can be a very complex condition to treat. There is no blood test to measure a "serum pain level" so good consultation and examination are crucial to all patient care. If you can help them, then you are obligated to do your best to care for that person. If not, you are obligated to give them reasonable options for further treatment. As always, document your findings and your treatment plan.

References

1. Amaro, J.A. "The First 50 Words" *Dynamic Chiropractic*.

2. Weiner, R.S. *Innovations in Pain Management* 1993:3.
3. Evans, R.C. *Illustrated Essentials in Orthopedic Physical Assessment.* St. Louis, Missouri: Mosby, 1994.
4. Hoppenfeld, S. *Physical Examination of the Spine and Extremities.* San Mateo, CA: Appleton & Lange, 1976.

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